		AND HUMAN SERVICES		10)31/27 0	FORM APPROVED	
CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES		OMB NO. 0938-039		
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION PM)	(X3) DATE SURVEY COMPLETED	
		095005	B. WING _	~	10/12/2007	
NAME OF F	PROVIDER OR SUPPLIER		STR	REET ADDRESS, CITY, STATE, ZIP CODE	2 <sub>2</sub>	
T145 1848	CHINGTON HOME			720 UPTON STREET NW	*	
THE WA	SHINGTON HOME		v	VASHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 000	INITIAL COMMENT	rs	F 000			
F 164 SS=D	An annual recertifice October 9 through deficiencies were be reviews, and intervisample included 28 of 183 residents the (1) supplemental re 483.10(e), 483.75(!) CONFIDENTIALITY.  The resident has the confidentiality of his records.  Personal privacy incommedical treatment, we communications, permeetings of family addess not require the room for each resident release of personal individual outside the The resident's right and clinical records resident is transferre institution; or record.	ation survey was conducted 12, 2007. The following ased on observations, record ews with the facility staff. The residents based on a census e first day of survey and one sident.  (4) PRIVACY AND  e right to personal privacy and or her personal and clinical cludes accommodations, written and telephone ersonal care, visits, and and resident groups, but this e facility to provide a private ent.  in paragraph (e)(3) of this t may approve or refuse the and clinical records to any e facility.  to refuse release of personal does not apply when the end to another health care release is required by law.	F 164	re-educated on Residents Rights i.e. privacy provided during dress changes.  2. Identification of Deficient Practices & Corrective Actions Other residents receiving dressin changes have the potential to be affected. The Director of Nursing designee will conduct impromptu observations of scheduled wound rounds to randomly monitor prival provided during dressing changes Any and all negative findings	e  2 2 3 3 4 5 5 5 6 6 6 6 6 7 7 7 7 7 9 9 and/or 1 cy 6 7 7 7 7 7 7 7 7 8 7 8 8 8 8 8 8 8 8 8	
	contained in the resi the form or storage release is required by	ident's records, regardless of methods, except when by transfer to another n; law; third party payment		will be corrected at time of discovand reported to the QA Committee recommendations.		
	I A	ERISUPPLIER REPRESENTATIVE'S SIGNA				
BORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN/	ATY/RE /	· /TITLE/	(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

\* PRINTED: 10/22/2007

PRINTED: 10/18/2007 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1' '	iultip Ilding	LE CONSTRUCTION	<u> </u>	COMPLI	
		(-/) 2 095005	B. WI	4G			10/1	12/2007
	PROVIDER OR SUPPLIER SHINGTON HOME			372	ET ADDRESS, CITY, S 20 UPTON STREET ASHINGTON, DC	w		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTIVE ACTION SHOWN THE APPROPRIESE OF	ULD BE	(X5) COMPLETION DATE
	This REQUIREME by: Based on observat determined that fact privacy for one (1) change and one (1) eye drops and testiful #12 and \$1.  The findings included 1. Facility staff failed Resident #12 durined During the initial tot 2007 at 8:35 AM, it dressing change bethe right foot/ankle, room was open. The around the resident The surveyor and faresident's room of for approximately the Employee #13 acknowledged #13 acknowledged have been closed decreased.	NT is not met as evidenced ions and staff interviews, it was cility staff failed to provide resident during a dressing resident prior to administering ng eye pressure. Residents  e: d to provide privacy for g a dressing change.  ur of the facility, on October 9, was observed that during a eing done by Employee #13 to the door to the resident's e curtain was not pulled 's bed.  acility staff stood outside the eserving the dressing change aree (3) minutes before lowledged the group outside  were made in the presence	F-/64	(2)	Privacy and Confid during dressing characteristics and confidence of the Provision of optimizing the provision of optimizing consultations.  Privacy and Confidence of the QA Committer of the QA Committer for changes in current the need for further.  Date of Committer of the privacy during consultations.  Incorrective of the privacy during consultations.  Identification of the provision of optimizing the provision of optimizing conduct randos scheduled ophthal monitor privacy propertion of the provision of privacy provision of pr	iewed its' currently re. Licensed staff in the provisions of 1.75 (I)(4) specifically entiality provided anges.  Iter and/or designee is intaining compliance, es a random observation of the complete a 10% audit reatments weekly to Findings will be reported for recommendation and iteration of the complete and iteration of mology services and iteration of mology services to covided. Any and all will be corrected at time ported to the QA	The ation iality fanager dit rted ons and s.	11/9/07

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	1	(X3) DATE	SURVEY PLETED
	•	0,95005	B. WING			10	/12/2007
NAME OF	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY	1	·	
THE WA	SHINGTON HOME			3720 UPTON STREE WASHINGTON, DO	1 3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	S PLAN OF CO RECTIVE ACTION ENGED TO THE DEFICIENCY)	RECTION I SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 164	Employee #17 was 2007 at approximate and remove a base a computer and per nurse's station. Em Resident S1, sltting with one (1) resident him/her. Employee and instilled eye drough the employee #17 returbelongings at the nudevice, went back to that he/she was me Employee #17 meast the resident's eyes.	observed on October 10, ely 3:30 PM to enter Unit 1A ball type cap. He/she placed sonal belongings at the aployee #17 approached in the common dining area at across the table from #17 introduced hlm/herself aps into the resident's eyes. ned to his/her personal airse's station and retrieved a to the resident and explained asuring eye pressure. Sured the pressure in both of	F 164	The facility has re and procedure. To inserviced by the provisions of 483.  (I)(4) specifically reprovided during of 4. Monitoring:  The Clinical Manaresponsible for matching the Confidentiality. The designee will compophthalmology confidentiality will be reproved for recommendation policy or practice a and or action plans.	viewed its' currely he Ophthalmolog Administrator on 10(e) and 483.7 rivacy and confil hithalmology self ger and/or design intaining compliantaining compliantaining compliantaining prief Clinical Manage lete a 10% audit sults to verify complet to the QA ns for changes if nd the need for	ist was he entiality clees. ee is nee. acy and or of scheduled appliance. Committee current other audits	10/12/07
F 253 SS=D	conducted immediat Employee #17 stated move the residents.' 483.15(h)(2) HOUSE The facility must promaintenance services anitary, orderly, and This REQUIREMENT by: Based on observation tour of the facility, it whousekeeping and mot adequate to ensure	vide housekeeping and as necessary to maintain a locomfortable interior.  T is not met as evidenced as determined that leaintenance services were are that the facility was manner as evidenced by:	F 253 F <b>253</b>	Marred and or day	maged basebood of 250, 312, 340 3 an repaired.  of Deficient Proposes in the second of	ctices  potential Manager ire facility I negative discovery	10/11/07

		AND HUMAN SERVICES				FORM	: 10/18/2007 I APPROVED
STATEMEN	RS FOR MEDICARE T OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095005	(X2) MU A. BUILD B. WING		<u>.</u>	(X3) DATE S COMPLI	
	PROVIDER OR SUPPLIER SHINGTON HOME		s	TREET ADDRESS, CITY, S 3720 UPTON STREET N WASHINGTON, DC 2	W		2/2001
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECT TIVE ACTION SHOU CED TO THE APPR EFICIENCY)	JLD BE	(X5) COMPLETION DATE
SS=D	marred/scarred furr were made in the pi Employee #3 on Oc AM and 10:30 AM.  The findings include 1. Five (5) of 20 bas damaged surfaces wrooms: 250, 312, 34 and 357.  2. Three (3) of 20 w damaged surfaces wrooms: 312, 354 and 357.  3. Marred and/or da were observed in the Third Floor - splinter four (4) of four (4) a Second Floor- five (4) dayroom and two (2) sitting areas.  Employees #2 and 3 cited deficiencies at 483.20(c) QUARTER A facility must asses quarterly review instand approved by CN once every 3 months	niture. These observations resence of Employee #2 and stober 9, 2007 between 7:25 es.  seboards with marred and/or were observed in the following 10, 354 and 367.  alls with marred and/or were observed in the following of the hallway outside of room maged furniture surfaces e following areas: red end table in the dayroom; rm chairs in the sitting area.  5) of five (5) arm chairs in the of three (3) arm chairs in the acknowledged the above the time of the observations.  RLY REVIEW ASSESSMENT as a resident using the rument specified by the State 15 not less frequently than	F 256	The facility has review and procedure. The lamintenance staff will by the Administrator or provisions of 483.15(It the maintenance of a and comfortable interior rounds have been expectly baseboard observations. The Director of Plant Compliance. The QA Fenvironmental observation interior. The house maintenance team least weekly environmental Administrator for monit Findings will be reported for recommendations of policy or practice and the audits and or action plants.	ved its' currently policinousekeeping and it be inserviced or designee on the name of the	e ng om	11/9/07

Based on staff interview and record review for one (1) of 28 sampled records, it was determined

by:

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILI	DING	COMPLETED	
		095005	B. WING	9	10/12/2007	
	PROVIDER OR SUPPLIER SHINGTON HOME		STREET ADDRESS, CITY STATE, ZIP CODE  3720 UPTON STREET NW  WASHINGTON, DC 20016			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 253	marred/scarred furr were made in the pi Employee #3 on Oc AM and 10:30 AM.  The findings included  1. Five (5) of 20 based damaged surfaces were rooms: 250, 312, 34  2. Three (3) of 20 wedamaged surfaces were rooms.	resence of Employee #2 and stober 9, 2007 between 7:25	F 25	1. Corrective Action(s)	ide of ces  eve the repring diffine of amiltee	
F 276 SS=D	were observed in the Third Floor - splinter four (4) of four (4) ar Second Floor- five (5 dayroom and two (2) sitting areas.  Employees #2 and 3 cited deficiencies at (483.20(c) QUARTER A facility must assess quarterly review instrand approved by CM once every 3 months  This REQUIREMENT by: Based on staff intervi	ed end table in the dayroom; m chairs in the sitting area.  5) of five (5) arm chairs in the of three (3) arm chairs in the acknowledged the above the time of the observations.  RLY REVIEW ASSESSMENT is a resident using the ument specified by the State S not less frequently than	F 276	maintenance staff will be inserviced by the Administrator or designee on the provisions of 483.15(h)(2) specifically the maintenance of a sanitary, orderly, and comfortable interior. Environmenta rounds have been expanded to include weekly wall observations for marring or damaged surfaces.  4. Monitoring: The Director of Plant Operations and/or designee is responsible for maintaining	the toring intenance rator Findings	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLÉ CONSTRUCTIO G	N .,	(X3) DATE COMP	SURVEY LETED
		095005	B. WIR	iG_	<u> </u>		10	12/2007
, , ,	PROVIDER OR SUPPLIER SHINGTON HOME			3	EET ADDRESS, CIT 720 UPTON STREE /ASHINGTON, D			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH COR	R'S PLAN OF CORRE RECTIVE ACTION SH RENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 253	marred/scarred furr were made in the pi Employee #3 on Oo AM and 10:30 AM.  The findings include 1. Five (5) of 20 bas damaged surfaces v rooms: 250, 312, 34 2. Three (3) of 20 w damaged surfaces v	iture. These observations resence of Employee #2 and tober 9, 2007 between 7:25	F 2	253 2 <b>53</b>	(3) Marred and or of the splintered el four arm chairs on the third floor dayroom and the sitting area were  2. Identification & Corrective Ac Other furniture s to be affected. If and or designee identify marred of Any and all negatime of discovery	e Action(s) amaged furniture surfa and table in the dayroom observed in the sitting the five arm chairs in the discarded immediately n of Deficient Practice ctions: urfaces have the poten the Housekeeping Man s will audited the facility or damaged furniture su tive findings will be cor y and reported to the Or commendations.	and the area the  s tial ager to rfaces. rected at	10/11/07
F 276 SS=D	were observed in the Third Floor - splinter four (4) of four (4) at Second Floor- five (5 dayroom and two (2) sitting areas.  Employees #2 and 3 cited deficiencies at 483.20(c) QUARTER A facility must asses quarterly review instrand approved by CM once every 3 months. This REQUIREMENT by: Based on staff interv	ed end table in the dayroom; m chairs in the sitting area.  5) of five (5) arm chairs in the of three (3) arm chairs in the acknowledged the above the time of the observations.  RLY REVIEW ASSESSMENT are a resident using the ument specified by the State S not less frequently than	F 27	76	and procedure. maintenance sta by the Administra provisions of 483 the maintenance and comfortable rounds have bee weekly observati  4. Monitoring: The Director of P is responsible for QA Program included for monitoring and maintenance weekly environme and/or designee will be reported to recommendation practice and the reaction plans.	ange(s): eviewed its' currently provided its' currently provided its' currently provided its in consistency of a sanitary, orderly, interior. Environmental nexpanded to include ons of furniture surfaces its interior. The house the environmental goal to the environmental goal to include interior. The house the interior. The house the interior. The house the interior compliance in currently in the QA Committee for monitoring compliance in currently included in the provided in the QA Committee for some incurrently included in the QA Committee for some included in the	designee e. The observation ekeeping ct random dministrator ce. Findings	11/2/07

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I I	A BUILDING	
095005	B. WING	10/12/2007
NAME OF PROVIDER OR SUPPLIER THE WASHINGTON HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3720 UPTON STREET NW WASHINGTON, DC 20016	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	D BE COMPLETION
F 253  Continued From page 3 marred/scarred furniture. These observations were made in the presence of Employee #2 and Employee #3 on October 9, 2007 between 7:25 AM and 10:30 AM.  The findings include:  1. Five (5) of 20 baseboards with marred and/or damaged surfaces were observed in the following rooms: 250, 312, 340, 354 and 367.  2. Three (3) of 20 walls with marred and/or damaged surfaces were observed in the following rooms: 312, 354 and the hallway outside of room 357.  3. Marred and/or damaged furniture surfaces were observed in the following areas: Third Floor - splintered end table in the dayroom; four (4) of four (4) arm chairs in the sitting area.  Second Floor- five (5) of five (5) arm chairs in the dayroom and two (2) of three (3) arm chairs in the sitting areas.  Employees #2 and 3 acknowledged the above cited deficiencies at the time of the observations. 483.20(c) QUARTERLY REVIEW ASSESSMENT  S=D  A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for one (1) of 28 sampled records, it was determined	F 276  1. Corrective Action(s) The MDS Coordinator has since completed a Quarterly MDS for Resident #19.  2. Identification of Deficient Practices & Corrective Actions: Other residents requiring a Quarterly MDS to be completed in July have the potential to be affected. The Clinical Manager and / or designee will audit current resident records to identify risks. Any and all negative findings will be corrected at time of discovery and reported to the QA Committee for recommendations.	10/19/07

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 OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION		(X3) DATE S COMPL	
		095005	B. WIN	IG		<del></del>	10/1	2/2007
	PROVIDER OR SUPPLIER SHINGTON HOME			372	ET ADDRESS, CITY, 20 UPTON STREET ASHINGTON, DC	NW		
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F 278	Minimum Data Set Resident #19.  The findings include A review of Resider quarterly MDS was The following MDS record with the follo Quarterly MDS No Quarterly MDS Aport MDS MDS MDS MDS Aport MDS MDS MDS Aport MDS MDS Aport MDS MDS MDS Aport MDS MDS MDS Aport MDS MDS MDS Aport MDS MDS Aport MDS MDS MDS MDS Aport MDS MDS MDS MDS MDS Aport MDS	failed to complete a quarterly (MDS) in July 2007 for at #19's record revealed that a not completed for July 2007. assessments were in the wing completion dates: ovember 5, 2006 and 30, 2007 for 25, 2007 assessment after April 25, DS 2.0 User's Manual", page on three quarterly the comprehensive uired in each 12-month period MDS standard system count ause there are never more consecutive three-month and are measured from the 20 of one assessment to Item	F 27		and procedure. The be inserviced by the designee on the pro specifically the timel review assessments audit the clinical recognaterly assessment during the monthly C	wed its' currently poli MDS Coordinators we Director of Nursing of visions of 483.20(c) y completion of quarter The Clinical Manager of monthly for completer than an another monthly for completer than an another monthly to monthly to monitoring or quarterly review as well conduct a randomonthly to monitoring than the QA Committed to the QA Committer and the Committer an	erly ers will eted  g. d esignee The itoring ssessments. om 10% compliance. etee for olicy or	11/2/07
SS=D	resident's status.	st accurately reflect the						·
	A registered nurse n	nust conduct or coordinate					-	

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		095005	B. Wil	۷G			10/·	12/2007
	PROVIDER OR SUPPLIER SHINGTON HOME			37.	ET ADDRESS, CITY, 20 UPTON STREET ASHINGTON, DC	NW		
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	Each individual who assessment must sithat portion of the activation of the activati	with the appropriate th professionals.  The professionals and certify that the pleted.  It completes a portion of the ign and certify the accuracy of issessment.  If Medicaid, an individual who ply certifies a material and resident assessment is mey penalty of not more than essment; or an individual who ply causes another individual and false statement in a set is subject to a civil money than \$5,000 for each  If it is not met as evidenced which and record review for five cords, it was determined that accurately code the Minimum meight for two (2) residents, and the see) Assessment Coordinator all assessments were ning at Section R2b for one into #5, 6, 11, 19 and 28.	F27	278 <b>8</b> (1)	1. Corrective Resident #5 has si and a significant of completed for the height in Section K  2. Identification of Corrective Action Other residents hat affected. The Resi will conduct a 100% records to identify infindings will be corrected to the recommendations.  3. Systemic Chan The facility has reviand procedure. The Coordinator and the be inserviced by the designee on the prospecifically resident emphasis placed on Coordinators have the MDS Certification Compliance. The Quaudit tool for monitor MDS. The Clinical Machiner is response compliance. The Quaudit tool for monitoring complian reported to the QA Corecommendations for policy or practice and audits and or action	Action(s) nce been reassessed orrection has been proper coding of his 2a.  If Deficient Practices ons: we the potential to be dent Assessment Coor 6 audit of currently clini isks. Any and all negal ected at time of discover QA Committee for QA Committee for the Registered Dietitian we Director of Nursing or existence of the November 20 assessments with special section K2a. The MD pourse for November 20 or of Nursing and/or ible for maintaining A Program includes an ing the accuracy of the Managers will conduct a later of the need for further of the need for further dithe need for further	cal tive ery t cy t cific S C 007.	10/12/07
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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B WING 095005 10/12/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3720 UPTON STREET NW THE WASHINGTON HOME WASHINGTON, DC 20016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 278 Continued From page 6 F 278 Corrective Action(s) 1. Facility staff failed to code the height for F278(2) Resident #6 has since been reassessed Resident #5 on the admission MDS. and a significant correction has been completed for the proper coding of her A review of Resident-#5's record revealed that an height in Section K2a for the most admission MDS was completed on August 9. current assessment. 2007. Section K2a, "Height" was coded as "0". 2. Identification of Deficient Practices & Corrective Actions: According to the "MDS 2.0 User's Manual" on Other residents have the potential to be page 3-150, "Record the resident's height." affected. The Resident Assessment Coordinator will conduct a 100% audit of currently clinical 0/19/07 A face-to-face interview was conducted with records to identify risks. Any and all negative Employee #8 on October 11, 2007 at 2:30 PM. findings will be corrected at time of discovery He/she acknowledged that the height should have and reported to the QA Committee for been coded. The record was reviewed October recommendations. 11, 2007. 3. Systemic Change(s): The facility has reviewed its' currently policy 2. Facility staff failed to code the height on the and procedure. Resident Assessment admission, quarterly and annual MDS for Coordinator and the Registered Dietitian will Resident #6. be inserviced by the Director of Nursing or designee on the provisions of \$3.20(g)-(j) A review of Resident #6's record revealed that the 11/2/07 specifically resident assessments with specific resident was admitted to the facility on December emphasis placed on Section K2a. The MDS 16, 2005. Coordinators have been enrolled in NSPAC MDS Certification Course for November 2007. Section K2a, "Height" was blank on the following 4. Monitoring: MDS assessments: The Assistant Director of Nursing and/or designee Admission completed December 27, 2005 is responsible for maintaining compliance. The Significant change completed March 16, 2006 QA Program includes an audit tool for monitoring Quarterly completed June 13, 2006 the accuracy of the MDS. The Clinical Managers Significant change completed July 28, 2006 will conduct a random 10% medical record audit Quarterly completed December 27, 2006 monthly to monitoring compliance. Findings will be Quarterly completed March 24, 2007 reported to the QA Committee for recommendations Quarterly completed June 25, 2007. for changes in current policy or practice and the need for further audits and or action plans. According to the "MDS 2.0 User's Manual" on 5. Date of Compliance: 11/09/07 page 3-150, "Record the resident's height." A face-to-face interview was conducted with

Employee #18 on October 9, 2007 at 2:00 PM.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	OF CORRECTION IDENTIFICATION NUMBER:	A BUILDIN	Ì	COMPL	ETED
		B. WING_			
	095005	B. WING _		10/	12/2007
NAME OF F	PROVIDER OR SUPPLIER		REET ADDRESS, CITY, STATE, ZIP	CODE	
THE WA	SHINGTON HOME 38		3720 UPTON STREET NW		
		\ <u>`</u>	WASHINGTON, DC 20016		<del></del>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCS	ON SHOULD BE E APPROPRIATE	COMPLETION DATE
F 278	Continued From page 7	F 278	A Compating Authority		
	He/she acknowledged that the resident's height	F 2781	1. Corrective Action(s) Resident #11 has since been re	essessed	
	should have been coded on the MDS and offered	C 2780	and a significant correction has	neen	10/12/
	no explanation for the missing heights. The	<i>(</i>	completed to include her diagnoted Chronic Renal Insufficiency.	is of "CRI"	10/12/07
	record was reviewed October 9, 2007.	ı		4	
	3. Facility staff failed to include a diagnosis of		2. Identification of Deficient F	actices	
	Chronic Renal Insufficiency on the significant		& Corrective Actions: Other residents with a diagnosis	of "CDI" have	
	change MDS for Resident #11.		the potential to be affected. The	Resident	
	A reculeur of Dogidant 4611b record recorded as	l	Assessment Coordinator will cor	liuct a 100%	in lial.
1	A review of Resident #11's record revealed an "Admission and Annual Physical Examination		audit of currently clinical records  Any and all negative findings will	lo identify risks.	10/19/07
İ	Form" dated January 9, 2007. Included under		at time of discovery and reported	to the QA	
	dlagnoses was, "CRI" (Chronic Renal	}	Committee for recommendations		1
}	Insufficiency).	ł	2 Constitued Dilamondo		1
	A review of the significant change MDS	1	<ol> <li>Systemic Change(s):</li> <li>The facility has reviewed its' curr</li> </ol>		
	completed August 21, 2007 revealed that "CRI"		and procedure. The MDS Coord	nator will	
ľ	was not included in Section I [Disease	}	be inserviced by the Director of h	Nitsing or	
.	Diagnoses].	ŀ	designee on the provisions of 48 specifically resident assessment:	20(g)-(j)	1/2/07
	According to the "MDS 2.0 User's Manual" on	ł	emphasis placed on "diagnosis."	The MOS	
	page 3-127, "Intent: To code those diseases or		coordinators have been enrolled	NSPAC	}
) i	infections which have a relationship to the		MDS Certification Course for Nov	mber 2007.	
- 1	resident's current ADL (Activities of Daily Living)		4 Montto-to-	. !	
	statue, cognitive status, mood or behavior status,		4. Monitoring: The Assistant Director of Nursing	and/or designee	,
	medical treatments, nursing monitoring or risk of death."	1	is responsible for maintaining com	hience. The	
	,		QA Program includes an audit tool the accuracy of the MDS. The Clir	or monitoring	
	A face-to-face interview was conducted with		will conduct a random 10% medica	record audit	11/09/
	Employees #2 and #8 on October 11, 2007 at	.	monthly to monitoring compliance.	Findings will be	107
5	approximately 10:15 AM. They both acknowledged that the resident's diagnosis of	, .	reported to the QA Committee for refor changes in current policy or pra	commendations	,
	CRI was not coded on the MDS. The record was	}	need for further audits and or action	plans.	
ļ r	eviewed October 11, 2007.	·		1	
	1. The PN Accessment Coordinates 5: 45 d.t.	}	5. Date of Compliance: 11/09/	1	
	I. The RN Assessment Coordinator failed to ensure that all assessments were complete on	1		<b>\</b>	
	he quarterly MDS prior to signing at Section R2b				
	or Resident #19.				
RM CMS-2587	(02-99) Previous Versions Obsolete Event ID: WUZV11	Facilit	v ID: WASHHOME IF	dentification short	

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PAGE 03/03

		I AND HUMAN SERVICES			ا ہ	ORM APPROVED B NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILI		(X3) [	DATE SURVEY OMPLETED
		095005	B. WING			10/12/2007
		TEMENT OF DEFICIENCIES	(D	STREET ADDRESS, CITY, S 3720 UPTON STREET N WASHINGTON, DC PROVIDER'S	IW .	
PRÉFIX TAG	* ·	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFEREN	TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)	
F 278	the RT signed the A Section AA9b, on A Assessment Coordi Section R2b, on Ap	nt #19's record revealed that Assessment Tracking Form, pril 30, 2007. The RN Inator signed the MDS, ril 25, 2007 indicating that all	F 278	The interdisciplinary te on the provisions of th p.3-212 "The RN Asse not sign and attest to d	on(s) eam has been re-educated le MDS 2.0 Users Manual essment Coordinator must completion of the assessme rs have finished their portion	
	3-212, "The RN Ass not sign and attest t assessment until all	DS 2.0 User's Manual" page sessment Coordinator must o completion of the other assessors have as of the MDS." The record		on the provisions of th p.3-212 "The RN Asse not sign and attest to o		nt 10/14/07
	admission MDS ass A review of Residen revealed an admissi	d to include diagnoses on the essment for Resident #28.  It #28's closed record ion MDS completed July 19, so diagnoses coded in Section		IDT will be inserviced to the provisions of 4th Manual p.3-212 specific requirements for the Manual p.3-212 specific requirements for the Manual Properties of the Manual P	ed its' currently policy Elinical Managers and the by the DON and or designer 83.20(g)-(j) & MDS 2.0 Use ically the signature linimal Data Set. The MDS	
	completed by the ph following diagnoses degeneration, left fe hemiarthroplasty (su According to the "Nu Assessment" comple following diagnoses hemiarthroplasty after The resident receive	moral neck fracture, left irgery June 30, 2007) ursing Admission eted July 6, 2007, the		4. Monitoring: The Assistant Director is responsible for main QA Program includes a the accuracy and signa for the Minimal Data So will conduct a random monthly to monitoring of reported to the QA Cor	of Nursing and/or designee taining compliance. The an audit tool for monitoring ature requirements et. The Clinical Managers 10% medical record audit compliance. Findings will be mittee for recommendation policy or practice and the and or action plans.	11/9/07
};	gait as a result of the	e left femoral fracture.				
				<u> </u>		

PRINTED: 10/18/200 FORM APPROVEI OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		STRÚCTI	ON :	(X3) DATE COMPL	SURVEY LETED
	•	095005	B. WIN	iG			10/	12/2007
		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	IĐ PRĒFI	3720 UPTO WASHING	ON STRI GTON, PROVID EACH CO	DC 20016 ER'S PLAN OF CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CRO	DSS-REF	ERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE
1	A review of Resider the RT signed the A Section AA9b, on A Assessment Coordi Section R2b, on Appliassessments were of According to the "Mi 3-212, "The RN Assign and attest to assessment until all finished their portion was reviewed on October 5. Facility staff failed admission MDS assign A review of Resident revealed an admission MDS assign and attest to assessment until all finished their portion was reviewed on October 5. Facility staff failed admission MDS assign A review of Resident revealed an admission MDS assign and the second to the histograph of the mist completed by the physical following diagnoses of the miarthroplasty (such assessment" completed by the physical following diagnoses of the miarthroplasty after the resident received the rece	at #19's record revealed that assessment Tracking Form, pril 30, 2007. The RN nator signed the MDS, ril 25, 2007 indicating that all completed.  DS 2.0 User's Manual" page essment Coordinator must be completion of the other assessors have as of the MDS." The record atober 11, 2007.  If to include diagnoses on the essment for Resident #28.  If #28's closed record on MDS completed July 19, or diagnoses coded in Section or and physical examination and physical examination are listed: macular moral neck fracture, left regery June 30, 2007)  It is gary June 30, 2007, the were listed: left hip are left femoral fracture.  If physical and occupational tent in walking, balance and left femoral fracture.	F 2 7 8	Resid  2. Ide & Corr Other Deger or left to be a Coordid audit of Any ar at time Comm  3. Sys The fac and pro Coordid of Nurs 483.200 The MI NSPAC 2007.  4. Mon The As: maintai an audi The Clir medical Findings recomm practice plans.	ent #28 har entification rective A residents heration, le hemiarthraffected. inator(s) wof currently and all negate of discovaittee for residents has recordure. In the company of the com	e Action(s) as since been discharged on of Deficient Practices ctions: with a diagnosis of "Macueft femoral neck fracture, oplasty have the potentia The Resident Assessmen vill conduct a 100% y clinical records to identificative findings will be corre ery and reported to the Quecommendations.  ange(s): eviewed its' currently politically Section I "Diagno andors have been enrolled triffication Course for November of November 1 (a) Program monitoring the accuracy of agers will conduct a rando did monthly to monitoring ported to the QA Commits for changes in current ported for further audits and thance: 11/9/07	ular and al fy risks. acted DA  icy at ctor of ases." d in ember  nsible for a includes f the MDS. om 10% a compliance. ttee for olicy or	10/19/07
	A face-to-face intervi	ew was conducted with						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1		LDING	CONSTRUCTION	- 7	COMP	
		095005	B. WIN	IG			10/	12/2007
	PROVIDER OR SUPPLIER SHINGTON HOME			3720	T ADDRESS, CITY UPTON STREE SHINGTON, DO			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORR	S PLAN OF CORRECTIVE ACTION SHOED TO THE APP	OULD BE	(X5) COMPLETION DATE
F 278	Employee #2 on Oo He/she acknowledg diagnoses listed for was reviewed Octo	ctober 10, 2007 at 8:45 AM. ged that there were no r Resident #28. The record	F 2	278	and her individua appropriately can need for oxygen	since been reassesse alized needs have bee e planned to include h therapy.	ner en	10/15/07
F 279 SS≃D	CARE PLANS  A facility must use to develop, review a comprehensive plant.  The facility must deplan for each reside objectives and time.	the results of the assessment and revise the resident's n of care.  velop a comprehensive care ent that includes measurable tables to meet a resident's	f279		& Corrective Ac Other residents in have the potential Manager and or the current clinic. Any and all negal at time of discove the QA Committee.	requiring oxygen thera al to be affected. The designee will audit 100 al records to identify ri- tive findings will be co ery and reported to ee for recommendation ange(s):	ppy Clinical 0% of sks. vrected	10/14/07
	needs that are identassessment.  The care plan must to be furnished to at highest practicable psychosocial well-be §483.25; and any se be required under § due to the resident's	describe the services that are tain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided as exercise of rights under the right to refuse treatment			The facility has reand procedure. The 24 hour repormaintaining complete will be inserdevelopment of cutilizing the provisus 483.20(k)(1) by the designee.  4. Monitoring: The Assistant Directory is responsible to the audit tool for monage and procedure.	eviewed its' currently parties and the daily review will be the mechanis bliance. The interdisciviced regarding the comprehensive care playing the process of 483.20(d) and the Director of Nursing ector of Nursing and/onsible for maintaining QA Program includes illoring the development	ursing v of im for iplinary ans or an	11/2/07
	by: Based on staff intent(2) of 28 sampled rethat facility staff faile appropriate goals ar resident on oxygen t	IT is not met as evidenced view and record review for two esidents, it was determined to initiate a care plan with ad approaches for one (1) therapy and one (1) resident trapy. Residents #6 and 8.			implementation I is specific care plan will conduct a ran-audit of care plans compliance. Find QA Committee for changes in curren the need for further plans.	adjustments of resider ming. The Clinical Mar dom 10% medical recommendations will be reported to recommendations for a policy or practice and a redistribution of audits and or action appliance: 11/09/07	nt nagers ord o the r d	•

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والمحارب والمراج والمستعلق فيقتض فيمان والمراج والمحارب والمحروب ويمير والمراج والمراج والمراج والمراج

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE CONSTRUCTION ILDING		ATE SURVEY OMPLETED  10/12/2007
	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, ST 3720 UPTON STREET N WASHINGTON, DC 2	W	10/12/2007
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY)	COMPLETION DATE
F 279	Facility staff faile appropriate goals a #6, who was on oxy	d to initiate a care plan with nd approaches for Resident	F21	therapy.	e been reassessed and ds have been appropriately le her need for anticoagulan	10/15/07
	directing, "Oxygen 2 cannula) for POX (measurement) less The care plan, last inot updated to inclu			or designee will audit to records to identify risks will be corrected at time the QA Committee for	:: icoagulants have the f. The Clinical Manager and 100% of the current clinical s. Any and all negative findi e of discovery and reported recommendations.	nos ///4/07
·	A face-to-face intervented in the control of the co	view was conducted with tober 11, 2007 at 9:30 AM. ed that there should have the use of oxygen therapy ewed October 11, 2007.  I to initiate a care plan with ad approaches for Resident		of comprehensive care	ed its' currently policy omprehensive nursing of the daily review of the mechanism for the interdisciplinary regarding the development plans utilizing the and 483.20(k)(1) by the	11/2/07
	#8, who was on anti- (Coumadin).  According to the adr physician on July 6, receiving Coumadin  A review of the resid July 6, 2007 and rev revealed that there v	nission orders signed by the 2007, the resident was		is responsible for mainta QA Program includes ar the development and im of resident specific care Managers will conduct a audit of care plans mont Findings will be reported recommendations for ch	n audit tool for monitoring plementation / adjustments	
1	Employee #11 on O	iew was conducted with ctober 10, 2007 at 3:00 PM. ed that a care plan for		5. Date of Compliance	ce: 11/09/07	

2.0

The supplementation of the supplementation of PRINTED: 10/18/2007 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCȚION		(X3) DATE SURVEY COMPLETED	
		095005	B. WING	<u> </u>	- 10/·	12/2007
	PROVIDER OR SUPPLIER SHINGTON HOME		37	EET ADDRESS, CITY, STATE, 2 20 UPTON STREET NW ASHINGTON, DC 20016	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 279	for Resident #8. Th October 10, 2007.	ge 11 by should have been initiated e record was reviewed  PREHENSIVE CARE PLANS	F 279			
SS=D	The services provid	ed or arranged by the facility onal standards of quality.		1. Corrective Action(s) Employee #17 has since be regarding the "Guidelines for in Health Care Settings," deby the CDC.	een re-educated or Hand Hygiene	10/11/07
	by: Based on observation it was determined the			2 Identification of Defi & Corrective Actions: Other residents receiving of consultations have the pote The ophthalmologist was re Administrator immediately a designated a private treatm provision of ophthalmology Director of Nursing and/or d conduct random observation	ohthalmology Intial to be affected. Idirected by the and has been ent area for the services. The lesignee will	10/19/07
	2007 at approximate and removing a base placed a computer at the nurse's station. Resident S1, sitting with one (1) resident him/her. Employee and instilled eye drown Employee #17 return belongings at the nudevice, went back to that he/she was meaning a base of the state of the	bbserved on October 10, bly 3:30 PM entering Unit 1A eball type cap. He/she and personal belongings at Employee #17 approached in the common dining area across the table from f17 introduced him/herself ps into the resident's eyes. hed to his/her personal rse's station and retrieved a the resident and explained asuring eye pressure. sured the pressure in both of		ophthalmology services to meand sanitation prior to service Any and all negative finding at time of discovery and reproduced time of discovery and reproduced as a Systemic Change(s):  The facility has reviewed its and procedure. The Ophthal redirected by the Administral inserviced by the NHA or deprovisions of 483.20(k)(3)(i) Care Plans and "Guidelines in Health Care Settings," device Center for Disease Control.	nonitor proper ice delivery. s will be corrected orted to the QA tions.  currently policy almologist was tor and will be signee on the Comprehensive for Hand Hygiene	10/12/07
	during the entire obs	to wash his/her hands ervation. A package of s was present on the table e resident was sitting.				

*\*:* \_

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

a de la completa de l PRINTED: 10/22/2007 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN	OF CORRECTION	DENTIFICATION NUMBER:	A. BUI	LDING			COMPL	FIED	
		095005	B, WIN	IG			10/	12/2007	
	PROVIDER OR SUPPLIER			3720	TADDRESS, CIT UPTON STRE SHINGTON, D				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH COR	ER'S PLAN OF CORF RECTIVE ACTION S RENCED TO THE AI DEFICIENCY)	HOULD BE COMPLÉTION		
F 281 F 323	According to "Guideline for Hand Hygiene in Health Care Settings," developed by the Center for Disease Control, October 25, 2002, page 34, "Decontaminate hands before having direct contact with patients."  483.25(h) ACCIDENTS AND SUPERVISION			23	responsible for QA Program in tool for monitor The Clinical Ma complete a 10° ophthalmology	anager and/or designer maintaining compliar icludes a random obs ring proper hand sanil anager and or designer audil of scheduled consults monthly to v	nce. The servation tation. ee will verify	1/9/07	
SS=E					QA Committee changes in curr need for further	indings will be reported for recommendations rent policy or practice raudits and or action compliance: 11/09/0	s for e and the plans.		
	by: Based on observation the facility, it was de failed to maintain an evidenced by a buck damaged skid strips broken over-bed light loose rubber molding observations were m	ons during the initial tour of stermined that facility staff a accident free environment as kled front lobby carpet, in residents' showers, a act cover and wall plate and g in a resident's room. These hade in the presence of 8 on October 9, 2007 from AM.							
		observed on October 9, trip over the buckled front							
	with damaged skid s	sident showers were observed strips that were lifting from the areas: Third floor first and B220.							

(X2) MULTIPLE CONSTRUCTION

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, .	(X2) MULT A. BÜİLDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1	095005	B. WING _		10/12/2007
	PROVIDER OR SUPPLIER		3	REET ADDRESS, CITY, STATE, ZIP CO 1720 UPTON STREET NW WASHINGTON, DC 20016	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 281	According to "Guide Health Care Setting for Disease Control	eline for Hand Hygiene in gs," developed by the Center l, October 25, 2002, page 34, nds before having direct	F 281		
F 323 SS=E	The facility must ensenvironment remain as is possible; and e	NTS AND SUPERVISION	F 323	1. Corrective Action(s) The front lobby carpet has since bee by hardwood floors.  2. Identification of Deficient Pract & Corrective Actions: Other carpeted areas in the facility hotential to be affected. The Directo Operations will inspect all carpeted a identify risks. Any/all negative finding corrected at time of discovery.	ave the or of Plant areas to
	by: Based on observation the facility, it was defailed to maintain an evidenced by a buck damaged skid strips broken over-bed light	ons during the initial tour of etermined that facility staff in accident free environment as kied front lobby carpet, is in residents' showers, a not cover and wall plate and g in a resident's room. These		3. Systemic Change(s): The facility has reviewed its' currently and procedure. The environmental staff have been inserviced by the Addor designee on the provisions of 483 specifically accidents and supervision Environmental rounds have been extincted carpet assessment, repair, mand or replacement.	services Iministrator 3.25(h) on. panded to
	observations were m Employees #2 and 3 7:25 AM until 10:10 A The findings include: 1. An employee was 2007 at 10:10 AM to lobby wall-to-wall can 2. Four (4) of 15 res with damaged skid s	nade in the presence of 3 on October 9, 2007 from AM.  s: sobserved on October 9, o trip over the buckled front irpet.  sident showers were observed strips that were lifting from the areas: Third floor first		4. Monitoring: The Director of Plant Operations and is responsible for maintaining complication for monitoring the interior. The land maintenance team leader will consider the monitoring compliance. Findings to the QA Committee for recommend changes in current policy or practice for further audits and or action plans.  5. Date of Compliance: 11/09/0	iance. The ental observation housekeeping onduct random he Administrator will be reported dations for and the need

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (2)  (3)  (3)  (3)  (4)  (5)  (6)  (7)  (9)  (9)  (9)  (9)  (9)  (1)		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED	
	·	095005	<u></u>			<u>10/</u>	12/2007
,	PROVIDER OR SUPPLIER SHINGTON HOME			372	ET ADDRESS, CITY, STATE, ZIP CO 0 UPTON STREET NW .SHINGTON, DC 20016	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	ĸ	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 281	Continued From pa	age 12	F 2	81			T
F 323 SS≃E	According to "Guid Health Care Setting for Disease Contro "Decontaminate ha contact with patient	eline for Hand Hygiene in gs," developed by the Center I, October 25, 2002, page 34, nds before having direct is."	F 3:	23	Corrective Action(s) The damaged skid strips observed ir shower rooms 367A, 220A, and 220I		10/4/07
55=E	environment remail as is possible; and	isure that the resident ns as free of accident hazards each resident receives on and assistance devices to	C323	(2)	2. Identification of Deficient Pract & Corrective Actions: Other resident showers rooms have potential to be affected. The Housek and Maintenance team leader will insall shower rooms to identify risks. Ar all negative findings will be corrected at time of discovery.	the keeping spect ny and	10/18/07
	by: Based on observati the facility, it was de failed to maintain an evidenced by a buc damaged skid strips broken over-bed lig- loose rubber moldin	ons during the initial tour of etermined that facility staff in accident free environment as kied front lobby carpet, is in residents' showers, a hit cover and wall plate and ig in a resident's room. These made in the presence of			3. Systemic Change(s): The facility has reviewed its' currently and procedure. The environmental s staff have been inserviced by the Adi or designee on the provisions of 483. specifically accidents and supervision Environmental rounds have been expinctude the assessment, repair, maint and or replacement of skid strips in reshowers.	ervices ministrator .25(h) n. panded to tenance,	11/2/07
	Employees #2 and 7:25 AM until 10:10  The findings include  1. An employee was 2007 at 10:10 AM to lobby wall-to-wall ca  2. Four (4) of 15 rewith damaged skids	3 on October 9, 2007 from AM.  5: cobserved on October 9, o trip over the buckled front arpet.  5: sident showers were observed strips that were lifting from the areas: Third floor first			4. Monitoring: The Director of Plant Operations and designee is responsible for maintaining compliance. The QA Program include environmental observation tool for monithe interior. The housekeeping and maintenance team leader will conveekly environmental rounds with the for monitoring compliance. Findings to the QA Committee for recommendate changes in current policy or practice afor further audits and or action plans.  5. Date of Compliance: 11/09/07	ng es the conitoring  nduct random e Administrator will be reported ations for and the need	11/9/07

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• · · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BÜILDII	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED
	<u>_</u>	095005	B, WING_		10/12/2007
	PROVIDER OR SUPPLIER SHINGTON HOME			REET ADDRESS, CITY, STATE, ZIP CODE 3720 UPTON STREET NW WASHINGTON, DC 20016	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 281	Health Care Setting for Disease Control "Decontaminate ha contact with patient	eline for Hand Hygiene in ys," developed by the Center , October 25, 2002, page 34, nds before having direct	F 281	Corrective Action(s)     The broken plastic cover on the over be in Room 307B has since been replaced.	
SS=E	environment remain as is possible; and	sure that the resident has as free of accident hazards each resident receives on and assistance devices to	F323(	2. Identification of Deficient Practices & Corrective Actions: The over bed lights in other resident roo the potential to be affected. The Housel and Maintenance team leader has insperesident room over bed light plastic coveridentify risks. Any and all negative finding be corrected at time of discovery.	ms have keeping cted all pers to
	by: Based on observation the facility, it was defailed to maintain an evidenced by a buck damaged skid strips broken over-bed light loose rubber moldin observations were in Employees #2 and 37:25 AM until 10:10 The findings include 1. An employee was 2007 at 10:10 AM to lobby wall-to-wall cause 2. Four (4) of 15 reswith damaged skid services and services are supplied to the findings include 1.	observed on October 9, trip over the buckled front rpet.  sident showers were observed strips that were lifting from the areas: Third floor first		3. Systemic Change(s): The facility has reviewed its' currently po and procedure. The environmental servi staff have been inserviced by the Admini or designee on the provisions of 483.25(specifically accidents and supervision. Environmental rounds have been expandinclude the assessment, repair, maintena and or replacement of over bed light plass covers in resident rooms.  4. Monitoring: The Director of Plant Operations and/or Designee is responsible for maintaining of The QA Program includes the environme Observation lool for monitoring the interior specifically the plastic covers of the over The housekeeping and maintenance tear will conduct random weekly environments with the Administrator for monitoring com Findings will be reported to the QA Comm for recommendations and or changes in composition of policy or practice and the need for further and or action plans.  5. Date of Compliance: 11/09/07	ices istrator h)  ded to ance, stic  compliance. ental or bed lights. m leader al rounds ipliance. nittee current

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD B. WING			SURVEY LETED 112/2007
	PROVIDER OR SUPPLIER SHINGTON HOME			REET ADDRESS, CITY, 3720 UPTON STREET WASHINGTON, DC	STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 F 323 SS=E	According to "Guide Health Care Setting for Disease Control "Decontaminate ha contact with patient 483.25(h) ACCIDEI	eline for Hand Hygiene in ps," developed by the Center , October 25, 2002, page 34, nds before having direct	F 28°	1. Corrective Act	ate cover observed in Room	10/11/07
	as is possible; and	each resident receives on and assistance devices to		& Corrective Actions The wall plate covers the potential to be affer and Maintenance teal environmental rounds	s: throughout the facility have ected. The Housekeeping	10/2/07
:	by: Based on observation the facility, it was defailed to maintain an evidenced by a buck damaged skid strips broken over-bed light loose rubber moldin observations were n	ons during the initial tour of etermined that facility staff a accident free environment as kled front lobby carpet, in residents' showers, a not cover and wall plate and g in a resident's room. These hade in the presence of 3 on October 9, 2007 from		and procedure. The estaff have been inservor designee on the prospecifically accidents Environmental rounds include the assessment of the facility.  4. Monitoring: The Director of Plant	wed its' currently policy environmental services viced by the Administrator ovisions of 483.25(h) and supervision.  have been expanded to nt, repair, maintenance, wall plate covers throughout	11/2/07
	The findings include  1. An employee was 2007 at 10:10 AM to lobby wall-to-wall ca  2. Four (4) of 15 res with damaged skid s	s observed on October 9, trip over the buckled front rpet. sident showers were observed strips that were lifting from the areas: Third floor first		QA Program includes tool for monitoring the plate covers. The how team leader will condurounds with the Admin Findings will be report recommendations for	ntaining compliance. The the environmental observation interior specifically the wall is sekeeping and maintenance act random weekly environmental istrator for monitoring compliance, ed to the QA Committee for changes in current policy or for further audits and or action ance: 11/09/07	11/9/07

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ULTIPLE CONSTRUCȚION LDING	(X3) DATE SURVEY COMPLETED	
	•	095005			10/12/2007
	PROVIDER OR SUPPLIER SHINGTON HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 UPTON STREET NW WASHINGTON, DC 20016	·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE COMPLETION
F 281 F 323 SS=E	According to "Guide Health Care Setting for Disease Contro "Decontaminate ha contact with patient 483.25(h) ACCIDE The facility must en environment remain as is possible; and	eline for Hand Hygiene in gs," developed by the Center l, October 25, 2002, page 34, nds_before having direct	F 2	1. Corrective Action(s) The loose rubber molding observed in t	ughout the The eader will fy risks. Any
	by: Based on observation the facility, it was defailed to maintain an evidenced by a buck damaged skid strips broken over-bed light loose rubber moldin observations were in Employees #2 and 37:25 AM until 10:10 The findings include 1. An employee was 2007 at 10:10 AM to lobby wall-to-wall ca 2. Four (4) of 15 reswith damaged skid servations.	observed on October 9, trip over the buckled front rpet. sident showers were observed trips that were lifting from the areas: Third floor first		3. Systemic Change(s): The facility has reviewed its' currently portion and procedure. The environmental serviced by the Admin or designee on the provisions of 483.25 (specifically accidents and supervision. Environmental rounds have been expansinclude the assessment, repair, maintent and or replacement rubber molding in downways throughout the facility.  4. Monitoring: The Director of Plant Operations and/or of is responsible for maintaining compliance QA Program includes the environmental tool for monitoring the interior specifically molding in door ways throughout the facily housekeeping and maintenance team lead conduct random weekly environmental rowith the Administrator for monitoring com Findings will be reported to the QA Commercommendations for changes in current practice and the need for further audits at plans.  5. Date of Compliance: 11/09/07	designee e. The observation the rubber lity. The ader will bunds upliance. nittee for policy or

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095005		A. BUI	(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING		-	SURVEY LETED		
	PROVIDER OR SUPPLIER SHINGTON HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3720 UPTON STREET NW WASHINGTON, DC 20016					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 371 SS=E	3. The plastic cover observed broken in over-bed lights observed. A wall plate cover hanging loose in rouplate covers observed. The rubber molding doorway of room 23 room doorways observed. Employees #2 and cited deficiencies at 483.35(i)(2) SANITAPREP & SERVICE. The facility must stop serve food under satisfactory.	r of the over-bed light was room 307B in one (1) of 20 erved.  r was observed damaged and om 336 in one (1) of 20 wall ed.  ng was observed loose in the 30 in one (1) of 20 resident erved.  3 acknowledged the above the time of the observations.  ARY CONDITIONS - FOOD	F3	71	1. Corrective Action(s) The 25 servings of mandarin orang of cookies, 54 serving of diet Jello, Jello, 9 serving of apple sauce, 15 fresh fruit salad, 17 servings of fres salad, 20 cups of ice tea, and 4 ser cocktails were discarded post observed.  2. Identification of Deficient Prace Corrective Actions: Other meal prep items prepared for	61 serving of servings of sh garden rying of fruit ervation.	10/9/07	
	by: Based on observation determined that facing prepare food under evidenced by: unlab moldy, wilted lettuce refrigerator, pans strand an uncovered divere made in the present that the present the present that the present that the present the present that the present	ons of the main kitchen, it was lity staff failed to store and sanitary conditions as eled and undated food, stored in the walk-in ored wet and ready for re-use umpster. These observations esence of Employees #5 and 07 between 6:55 AM and			meal distribution and storage have to be affected. The Food Services Ma Food Services Supervisor will inspetitems prior to storage for proper laboraticals. Any and all negative findings corrected at time of discovery.  3. Systemic Change(s): The facility has reviewed its current and procedure. The dietary services inserviced by the Registered Dietitia on the provisions of sanitary conditions, items.	the potential to enager and or ect any/all food els, dates, and s will be tly policy s staff will be en or designee ecifically	10/9/07	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN		) DATE SURVEY COMPLETED				
		095005	B. WING _		<del></del>	10/	12/2007	
ĺ	PROVIDER OR SUPPLIER		3	EET ADDRESS, CIT 720 UPTON STREE /ASHINGTON, D				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRÉFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE				
F 371	1. The following iter and/or unlabeled in 25 servings of many packages of cook 54 servings of diet of 1 servings of apples 15 servings of fresh 17 servings of fresh 20 cups of iced tea 4 servings of fruit cook 2. Seven (7) heads moldy and wilted in 3. The following item for re-use:	ms were observed undated the walk-in refrigerator:	F 371	Report weekly for Dietary Inspection conditions, food principal street Findings will be recommendation or practice and the or action plans.	complete the Dietary I or maintaining complian in Report now includes prep, and storage of for eported to the QA Com is for changes in current e need for further audit impliance: 11/09/07	nce. The s sanitary nod items. nmittee for nt policy	11/9/07	
F 441 SS=D	Five (5) of 14 hotel prive (5) of five (5) %. Two (2) of two (2) round (2) round (2) round (3) five (4) five (5)  pans hotel pans pasting pans hipster was observed to h and was uncovered.  5 acknowledged these of the observations.	F 441						

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		095005	B. WING _		10/12/2007
	PROVIDER OR SUPPLIER SHINGTON HOME		:	REET ADDRESS, CITY. STATE, ZIP CO 3720 UPTON STREET NW WASHINGTON, DC 20016	)DE ·
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLÉTION
	and/or unlabeled in 25 servings of may packages of coordinates of servings of diet of servings of apple 15 servings of free 17 servings of free 17 servings of free 18 servings of fruit of 18 servings of fruit of 19 servings of 19 servings of 19 servings of fruit of 19 servings of 19 s	ems were observed undated in the walk-in refrigerator: Indarin oranges obties I Jello O esauce of fruit salad of garden salad of cocktail I of lettuce were observed in the walk-in refrigerator. I man were stored wet and ready of salad of salad of the walk-in refrigerator. I pans I pans I pans I hotel pans I pans I hotel pans I pans I hotel pans I pans I pans I hotel pans I pans	F 371 (12)		ded immediately.  Ices  red for distribution e Food Services sor will inspect any oper labels, dates, ings will be  policy staff will be or designee on ally sanitary food items.  Inspection ance. The nitary conditions, ns. Findings for ent policy
SS=D	The facility must es infection control prosafe, sanitary, and to prevent the deve disease and infection control	stablish and maintain an ogram designed to provide a comfortable environment and elopment and transmission of on. The facility must establish program under which it ols, and prevents infections in			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ULTIPLE CONSTRUCȚIOI DING		DATE SURVEY COMPLETED		
		095005	B. WIN	G		10/12/2007		
NAME OF PROVIDER OR SUPPLIER  THE WASHINGTON HOME			STREET ADDRESS, CITY, STATE, ZIP CODE  3720 UPTON STREET NW  WASHINGTON, DC 20016					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORE	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRI DEFICIENCY)			
F 371	Continued From pa	_	F 3					
		ms were observed undated the walk-in refrigerator:	F371	The 10 sheet pans hotel pans, and the were re-washed a	Action(s)  5 hotel pans, the 5 "5-1/4"  2 roasting pans stored wet  nd stored appropriately.	10/9/07		
·	25 servings of man 9 packages of cook 54 servings of diet 61 servings of Jello 9 servings of apple 15 servings of fresh 17 servings of fresh 20 cups of iced tea 4 servings of fruit co	ries Jello sauce n fruit salad n garden salad		& Corrective Acti Other sheet pans potential to be affer and or Food Serving pans post wash for the control of	washed and stored have the cted. The Food Services Man ces Supervisor will inspect she proper drying and storage. We findings will be corrected at	et ///07		
	moldy and wilted in	of lettuce were observed the walk-in refrigerator. ns were stored wet and ready		The facility has rev and procedure. The staff will be inservi or designee on the	riewed its' currently policy e dietary services ced by the Registered Dietitian provisions of 483.35(i)(2) y conditions, food prep, and	11/2/07		
,		pans 4 hotel pans		Report weekly for r Dielary Inspection food prep, and the i.e. pot and pan ite QA Committee for	omplete the Dietary Inspection maintaining compliance. The Report includes sanitary condiproper storage of food and utems. Findings will be reported trecommendations for changes actice and the need for further	tions, ensils to the in		
F 441 SS=D	findings at the time 483.65(a) INFECTION		F 44	5. Date of Com	pliance: 11/09/07			
	infection control pro safe, sanitary, and o to prevent the devel disease and infectio an infection control	gram designed to provide a comfortable environment and opment and transmission of n. The facility must establish program under which it s, and prevents infections in						

		H AND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 10/22/2007 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		095005	B. WING		10/12/2007
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	· ·
THE WA	SHINGTON HOME		Į l	3720 UPTON STREET NW WASHINGTON, DC 20016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 371	1. The following ite	ems were observed undated	F371		
	and/or unlabeled in 25 servings of mar 9 packages of coo 54 servings of diet 61 servings of Jelk 9 servings of apple	kies Jello o	F 7 "	Identification of Deficient Practice     Corrective Actions:     Other temporary roll away dumpsters have potential to be affected. The Director of will inspect all dumpsters to identify risk negative findings will be corrected at time discovery.	ave the f Plant Ops
		h garden salad a		3. Systemic Change(s): The facility has reviewed its' currently present and procedure. The maintenance and of staff will be inserviced by the Registered or designee on the provisions of 483.35 specifically sanitary conditions, food prestorage of food items.	dietary d Dietitian (i)(2)
	3. The following ite for re-use:  10 of 14 sheet pan Five (5) of 14 hotel Five (5) of five (5) 1 Two (2) of two (2) r	pans ¼ hotel pans		4. Monitoring: The Dietitian will complete the Dietary In Report weekly for maintaining compliand Dietary Inspection Report includes sanitifood prep, and storage of food items. Fireported to the QA Committee for recomfor changes in current policy or practice need for further audits and or action plan	ce. The ary conditions, ndings will be amendations and the
		mpster was observed to sh and was uncovered.		5. Date of Compliance: 11/09/07	
F 441		15 acknowledged these of the observations. ON CONTROL	F 441		
SS=D	infection control pro safe, sanitary, and to prevent the deve disease and infection an infection control	stablish and maintain an ogram designed to provide a comfortable environment and elopment and transmission of on. The facility must establish program under which it ols, and prevents infections in			

	TMENT OF HEALTH AND HUMAN SERVICES RS FOR MEDICARE & MEDICAID SERVICES	FRINTED. 10/22/ FORM APPRO OMB NO. 0938-			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		DATE SURVEY COMPLETED
	095005	B. WING		<u></u>	10/12/2007
	PROVIDER OR SUPPLIER SHINGTON HOME	37	ET ADDRESS, CITY, S 20 UPTON STREET I ASHINGTON, DC	W	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PRÉFIX TAG	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)	
F 371	Continued From page 14	F 371			
	The following items were observed undated and/or unlabeled in the walk-in refrigerator:				
	25 servings of mandarin oranges 9 packages of cookies 54 servings of diet Jello 61 servings of Jello				
	9 servings of applesauce 15 servings of fresh fruit salad 17 servings of fresh garden salad 20 cups of iced tea 4 servings of fruit cocktail				
	Seven (7) heads of lettuce were observed moldy and wilted in the walk-in refrigerator.				
	3. The following items were stored wet and ready for re-use:				
	10 of 14 sheet pans Five (5) of 14 hotel pans Five (5) of five (5) ¼ hotel pans Two (2) of two (2) roasting pans				
	The roll away dumpster was observed to contain bags of trash and was uncovered.				
	Employees #5 and 15 acknowledged these findings at the time of the observations. 483.65(a) INFECTION CONTROL	F 441			
	The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in		Corrective Ac Employee #13 has t facility's policy, proc maintaining a sanita	peen re-educated on the edure, and practice for	10/10/07
	67(02-99) Previous Versions Obsolete Event ID: WUZV11	Facility	ID: WASHHOME	If continuation	sheet Page 15 of 19

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	ULTIPLE CONSTRUCTION LDING		· · · · · · · · · · · · · · · · · · ·	(X3) DATE SURVEY COMPLETED	
		095005	B. WIN	IG			10/	12/2007
NAME OF PROVIDER OR SUPPLIER THE WASHINGTON HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 UPTON STREET NW WASHINGTON, DC 20016					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRE CROSS-REFEREI	PLAN OF CORRECTIVE ACTION SHO NCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	isolation should be resident; and main corrective actions of the resident; and main corrective actions of the resident; and main corrective actions of the resident the environmental of the environment as evicobserved in the hall made in the present the findings included the findings included the present the findings included the findings included the findings included the findings included the findings included the hallway in front the findings included the hallway in front the findings included the hallway in front of the findings included the findings included the findings included the hallway in front of the findings included t	what procedures, such as applied to an individual tains a record of incidents and telated to infections.  NT is not met as evidenced ion and staff interview during tour, it was determined that to maintain a sanitary denced by a red biohazard bag lawy. This observation was ce of Employees #2 and 3.  The facility on October 9, 2007 observed that a red biohazard etious waste was observed in of an isolation room. Inside the resident's room.  Wiew was conducted with october 9, 2007 at 8:40 AM. St placed the bag here [in the ne isolation room] a second wiew was conducted with october 10, 2007 at 12:00 PM. The facility's practice was to nezard bag from the isolation ely place it in the soiled utility iate biohazard container and	F 4	141	& Corrective Actio Other residents recichanges with known the potential to be a of Nursing and/or dimpromptu observat rounds to randomly and proper destruct Any and all negative at time of discovery Committee for record.  3. Systemic Chang The facility has revite and procedure. Lice on the provisions of specifically to maintacomfortable environs development and trainfection.  4. Monitoring: The Clinical Manage responsible for main QA Program include tool for monitoning sa Clinical Manager and a 10% audit of schedweekly to verify com reported to the QA C for changes in currer the need for further a	eiving dressing isolation needs have ffected. The Director esignee will conduct ions of scheduled wo monitor sanitary cond- ion of contaminated r findings will be corre- and reported to the Conmendations.  ge(s): wed its' currently pol- nsed staff will be ins 483.65(a) specificall sin a safe, sanitary, a nent and to prevent the nsmission of disease r and/or designee is aining compliance. The or designee will confulle wound treatment of the conditions. The or designee will confuse will confuse the conditions will ommittee for recomment the policy or practice and	e round ditions materials. ected QA dictions ected QA dictions and dic	11/2/07
	left on the floor.	ord bag should not have been	F 44	15				

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	•	I AND HUMAN SERVICES & MEDICAID SERVICES		,		APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) Mi	ULTIPLE CONSTRUCTION DING	(X3) DATE : COMPL	SURVEY
		095005	B. WIN	G	10/	12/2007
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP ( 3720 UPTON STREET NW WASHINGTON, DC 20016	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
	transport linens so a infection.  This REQUIREMEN by: Based on observation of manufacturer's must facility staff failed program to ensure of facility and resident manufacturer's reconstruction of the findings include.  The findings include An observation of the was conducted on Cemployee #14 states of towels. I am goin A list describing each for that formula was washing area.  The washer being of computer program designed for the time of the obset on Cycle #1 and	andle, store, process, and as to prevent the spread of as to prevent the spread of as to prevent the spread of as to prevent the spread of as to prevent the spread of as to prevent the spread of the vash water temperatures for laundry were within the mmended range for each the washing cycle.  The laundry being processed october 9, 2007 at 8:40 AM. and and items washed go to select Cycle #1."  The formula and items washed posted on the door to the conserved was equipped with a sisplayed on a digital screen of the washer. Among the down the formula/cycle (a preach type of laundry), the the water temperature in (F).  Servation, the machine was	F 44		re-educated protocol, and mperatures ent the spread  Practices  speed and with the peratures event the upervisor machines ate chemical hits, and  hilly policy monitoring hits, and serviced ally infection ditoring program.  gnee is since. The oring tool for dry Supervisor kly audits be reported adations citice and plans.	10/11/07
		nputer screen was 95				

-		I AND HUMAN SERVICES  & MEDICAID SERVICES						APPROVED 0. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION		(X3) DATE S	SURVEY
		095005	B. WI	۷G _			1 <u>0/</u>	12/2007
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY,			
THE WA	SHINGTON HOME				VASHINGTON, DC	i		ĺ
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE	S PLAN OF CORRECTIVE ACTION SHOULD TO THE APP	OULD BE	(X5) COMPLETION DATE
F 445	Continued From pa	ge 17	F	145				
	temperature was re stated, "It has to be use different chemi- unable to state the	I Employee #14 what quired for this step. He/she 160 degrees to wash. We cals, too." Employee #14 was length of time the water wash cycle had to remain at						
	the laundry staff or	t, there was no evidence that the laundry supervisor were rature ranges for the ne facility's laundry						
	the temperature ran manufacturer for the facility's laundry. En	for the chemicals used and ge recommended by the chemicals used in the apployee #14 stated that that information, but would						
-	were being monitore #3 stated that the co pre-determined the and was set by the r	Employee #3 if temperatures ed for each step. Employee emputer program temperature for each cycle epresentative from the or the chemicals utilized by						
	for temperature rang	ufacturer's recommendations ges for the chemicals could inployee #3 at the time of the						
	facility's chemical su manufacturer's reco for each chemical us	sted information from the applier regarding the mmended temperature range sed. Information was ity via facsimile from the						

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PRINTED. IVIZZIZUVI DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 095005 10/12/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3720 UPTON STREET NW THE WASHINGTON HOME WASHINGTON, DC 20016 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE (X4) ID 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 445 Continued From page 18 F 445 facility's chemical supplier on October 10, 2007 at 8:50 AM. Employee #3 acknowledged that temperatures were not monitored for the washing cycle.

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